References and notes

(1) Brockington C F. *A Short History of Public Health.* London: J & A Churchill, 1966. See also Cartwright F F. *A Social History of Medicine.* London: Longman, 1977.

(2) Benjamin B. *Medical records.* London: Heinemann, 1980: 8, 217. This is a textbook for the examinations of the Association of Medical Record Officers. See also *Report of the Committee on Data Protection (Lindop Report).* Cmnd 7341. London: HMSO, 1978: Chap 7.

(3) If only because it has not yet been recognised as a matter of law, see *The Report of the Younger Committee on Privacy.* Cmnd 5012. London: HMSO, 1972.

(4) *Report on Breach of Confidence.* Cmnd 8388. London: HMSO, 1981: para 3.1.

(5) Supreme Court Act 1981 sections 33–35. This repeals and re-enacts with amendments the provisions of the Administration of Justice Act 1970 sections 31 and 32. The amendments concern clarification of the Court's power to confine the disclosure to medical or legal advisors. It reverses the rule in *McIvor* v *Southern Health and Social Services Board* [1978] 1 W L R. 260.

(6) Jackson M. Psychologists lose right to keep reports secret. *Times Educational Supplement* 1981 Aug 14.

(7) *Tarnesby* v *Chelsea and Kensington and Westminster (AHA) (T)* [1981] I R L R. 369.

(8) Cartwright F F. See reference (1).

(9) *Handbook of Medical Ethics.* British Medical Association, 1980. This book insists on the doctor's ultimate responsibility for medical confidences.

(10) Beauchamp T L, Childress J F. *Principles of Biomedical Ethics.* London and New York: Oxford University Press, 1979: 209–217.

(11) See reference (10) p 234.

(12) *The Lindop Report.* See reference (2) para 24.05.

(13) *Report of the Commission of Inquiry into the Confidentiality of Health Information.* Toronto, Ontario, 1980; Chaps 16, 23. The former deals with the supply of medical information to the police.

Commentary 2: Confidentially speaking

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Few doctors now take any form of Hippocratic oath when they qualify, they just learn medicine and are grateful to pass their final exams. However, whether or not they have discussed ethics as students, they will usually have some idea that it is not ethical (etiquette) to break confidence with patients who tell them about themselves. They may read in the generally unhelpful short texts on medical ethics that it may be illegal to withhold information from a court – but that it would not be ethical to divulge confidential information to other people without the patient's consent. Does the doctor's position differ from the priest in the confessional? There has been considerable discussion about the intentional or unintentional disclosure of patients' records, thus breaking confidentiality, but there has been somewhat less concentration on the verbal breaking of confidences. Is there any essential difference between documented records and the spoken word?

How carelessly do we give away personal information to all and sundry, let alone to a judge who is threatening us with committal to prison for contempt of court, which might harden our resolve to stay silent, sometimes without any reason to suppose that it might benefit our patient? Are there times when we should tell other people private details without a patient's permission, in the hope that they may be helped, or to protect others from possible harm, or just in the general belief that the 'law of the land' should be upheld?

Mixed up with the issue of ethics and confidentiality is the way that many of us probably do chat about patients, to medical colleagues and students, and even with our relatives and friends, and sometimes casual acquaintances. At the same time, even if we are conscientious in protecting our patients' confidences how much do we really take them into our confidence and tell them about their diagnoses, management, medication and so on in a one-to-one relationship rather than with the all-too-common God-child paternalism so often seen in doctors?

To what extent are patients consulted about their confidential rights in the teaching setting? They should, of course, be told 'this is a teaching hospital' and tacitly acknowledge that non-medical and even unqualified people are present when they are talking to the consultant or other doctors on the team, and these other people will know something about the patients' private lives. The accepted physical presence of other people during a doctor-patient discussion, usually nurses or medical student, and sometimes a social worker, may be tacitly assumed to have given the doctor permission to proceed with the other person(s) present. The patient may, wrongly or rightly, assume that these other people are bound to the same confidentiality as exists with the doctor. There seems to be no other general situation where the doctor can assume any implicit permission to broadcast any private information.

Another aspect of the teaching situation is the need to ask patients to consent formally to photographs being taken for teaching purposes, rather than just to be filed in the notes as a medical record. With the increasing use of video equipment in general practice as well as hospital, and the way in which video material lends itself to clever editing, a doctors may learn to their cost, it is possible that

patient's remarks, physical signs and psychological traits may be broadcast freely, in true or distorted form, far beyond normal confidentiality, and in perpetuity.

To use the vernacular, it is a 'cop-out' for a psychiatrist to write to a GP or colleague who has referred a patient that this letter is private and confidential and only for the attention of the person (doctor) to whom it is addressed, when a list of six people, to whom carbon copies are being sent, is appended. Sometimes a different, less technical letter, is sent by doctors to a social worker, physiotherapist or teacher but surely the implication is the same – a confidence is broken unless the patient is told that other people may be told and their help enlisted. Occasionally, the doctor may be led into this trap unintentionally by replying to some administrative or bureaucratic request for simple information about a patient on his list, or under his care as an in- or out-patient, *eg* about schools, housing or pensions. These problems may be more common in hospitals, where the doctors concerned may not feel the same immediate personal responsibility as the patient's GP. Surely, a confidence is just as confidential in the out-patient clinic or ward as in the sanctum of the family doctor's surgery or the patient's bedroom. There is even more dissemination of confidential information by word-of-mouth to nurses, therapists and social workers *eg* during case conferences, as part of 'normal accepted everyday' conduct, but how much are we entitled to spread private details around?

Of course, it would be almost impossible to deal with patients quickly and effectively without working in this way and patients presumably understand this because few doctors, or lawyers, will ever have had complaints made about such breaking of confidences. How could we cope, we say to ourselves (if we worry about it at all) if we did not fill in the personal details on laboratory forms for pregnancy tests or serology for venereal disease, or on letters to a community physician about a patient with TB? We need to tell ward clerks and ambulance controllers about patients, otherwise how would they arrange for their admission? GPs rely heavily on their receptionists for a host of paramedical (professional) as well as administrative duties. The processing of information about patients, on forms and letters is obviously carried out by laboratory, secretarial and other staff who do not necessarily have any obligation to abide by any rules of ethic or etiquette. Little wonder that patients and doctors have worried about 'information linkage' about large patient groups, *eg* maternal mortality, or non-accidental child injury, however well-intentioned the scheme. Clearly, recorded facts are particularly vulnerable to third parties. The Problem Orientated Medical Record approach has been used to document patients' problems as a way of enhancing management that is particularly valuable in teaching. The listing of patients' problems as a distillate of all the things that are wrong with them can facilitate the free dissemination of confidential information.

A doctor may feel that he can help a patient by disclosing information without asking permission (perhaps because he does not want to risk being refused) or by going against a patient's wishes. In spite of considerable discussion there is not yet any agreed view on whether information given to doctors by under sixteens (usually in respect of family planning or advice on pregnancy), is absolutely confidential or may be disclosed to parents without permission from the minor. Disclosure is perhaps most likely to be a problem in areas of psychiatric illness, even when the illness is not severe enough to make the patient legally incompetent. In the case of medico/legal incompetence the opinion of next-of-kin, close friend, lawyer or doctor are the guideline, as in consent to anything.

A recent book on ethics (1) examines some of the problems in the field of psychiatry. These include not only the problem of maintaining confidentiality and at the same time meeting any need to be accountable and responsible to relatives, friends and society generally who may be affected by mentally ill patients but also how to meet the need to be contractually equal with patients (which is an increasing tendency in Western medicine) yet at the same time to have a friendly paternalism towards patients which often seems to be necessary for successful psychiatric practice. Following on this point the book also looks at another interpretation of the word confidence, examines how psychiatrically ill patients may be treated effectively, while maintaining their confidence and, if necessary, explaining their illness to them.

Patients with depression, dementia or drinking problems spring to mind in this difficult area especially if they are alleged to have committed, or been convicted of a crime.

It is interesting that in a successful police scheme in Essex, elderly people arrested or reported for a criminal offence may be referred to another agency (*eg* GP or social worker) only with the knowledge and consent of the 'offender' (2). The referral does not indicate that the police involvement was the result of an alleged crime. The coordinating officer believes that this system has directly benefited some elderly people (especially those who were depressed and may have been suicidal) as well as avoiding the stress of court appearance, by using the alternative of a caution, combined with medical or social referral. The re-offending rate seems low.

A similar scheme has been suggested for doctors faced with a patient who asks them whether he is unfit to drive or whom the doctor believes may be unfit. The doctor can ask the Driver and Vehicle Licensing Centre (DVLC) at Swansea for advice. The medical advisers at the DVLC may advise the

doctor that the disabilities described, or their mildness, do not constitute any bar to obtaining a licence, or that the already licensed patient should take another test, or that the patient should not drive. The onus on doctors to protect patients from harm if they drive with disabilities has become particularly important since 1976 when the licence-till–70 was introduced, and because most people with disabilities or illnesses will rely on their doctor to advise them about the rules and their eligibility to drive (3).

As the onus in law is on the driver to declare any disability when he applies for a licence, or if one arises when he already has a licence, what should the doctor do if the patient refuses permission for him to contact the DVLC? The patient may be at risk if he drives, or may harm others if he has an accident. Even if the patient is physically capable but mentally ill, depressed or demented he may be a dangerous driver, but if he is not certifiable is the doctor entitled to notify the DVLC against his wishes? Of course it may be easy to 'solve' the situation by involving relatives or friends, and asking them to 'persuade' the patient not to drive, or to hide the keys or rotor arm in the case of the demented patient, but this is still breaking confidence, albeit not so obviously as ringing Swansea. The medical advisers there might suggest, and would probably be supported by the BMA Ethical Committee, that an 'anonymous' call to the DVLC indicating that the caller was a doctor and giving the 'patient's' name and address would only mean that a polite letter would be sent to the person specifically asking whether he or she had any proscribed disabilities or advising another test.

The alcoholic driver is a special problem. He may injure himself or others. If he can drive a car, however badly, and still be conscious with a blood alcohol level of 300 mg per cent or more he is in urgent need of medical help. Should his doctor tell here? Should the Police Surgeon tell his GP urgently when he gets the laboratory analysis? The same dilemmas apply, but much more rarely for most doctors if they have drug addicted patients who may harm themselves or pass drugs on to others, whether or not driving is involved. Many doctors would feel they might try and get out of the ethical dilemma by not raising the issue of confidentiality if consulted by an addict or peddler and therefore feeling they could notify someone else, even the police. Criminals, even murderers, may ask doctors to treat them but not tell anyone what they have done. The doctor might tell such patients he would only treat them if they agreed to the disclosure of information.

Depressed and potentially suicidal patients are another group who may pose dilemmas of confidentiality. Doctors may feel that a patient is not necessarily ill enough to require compulsory admission to a psychiatric hospital, but may feel that close relatives need to be informed of the situation so that they can 'keep an eye' on the depressed person. Aiding and abetting a suicide is, of course, still a crime, and doctors and nurses must be particularly careful not to be seen to be conniving in any way in a depressed person's suicidal act, however bleak that person's future (*eg* in affliction by widespread carcinomatosis or multiple disabling pathology). The Samaritans work on the basis that they do not reveal confidants' names. In CRUSE the (National Council for the Widowed and their Dependants) we have recently been wondering whether counsellors dealing with depressed possibly suicidal bereaved people should be advised to notify the counselled person's doctor, even if the 'patient' has asked them not to.

Ethics are not laws, but like laws they tend to evolve. The ethics about naming doctors have changed (see recent GMC booklets on professional conduct) but this is more etiquette than ethics. Neither the GMC booklet nor the BMA *Handbook* on medical ethics really help as there seems to have been little obvious evolution from the long-held Hippocratic view of confidentiality being sacrosanct. Incidentally, it is the GMC who might be regarded as the authoritative body as they are responsible for the registration *ie* standards, of doctors, rather than the BMA who do not represent all doctors. Doctors have little or no teaching on ethics in many British medical schools, take no specific medical oath at qualifying, and may not belong to the BMA. They may look at the GMC booklet, but many doctors are presumably working on the basis of what is society's traditional view. Patients do not usually expect us to disclose private information, and may specifically ask us that what they are telling us should remain confidential.

The two papers published in this issue on the topic of confidentiality both seem to uphold this general view. However, I have recently had my attention drawn to one possible legal loophole. If someone is pursuing a claim for personal injury alleged to have been caused while he was looked after as a patient in hospital, his solicitors are entitled to see the in-patient notes, even though the doctor in charge had not consented. The authority given to me on this point is that a personal injury action pursuant to Order 25, Rule 8 of the Rules of the Supreme Court means that there is an automatic direction that there should be 'discovery of documents and inspection thereof' by a plaintiff's solicitors. Indeed, the plaintiff's solicitors could claim expenses in respect of an application to see notes, if their release had been denied despite this Supreme Court Rule. All documents having any relevance to the action would have to be listed and would therefore be available to the plaintiff's solicitors for inspection.

Obviously, this area of compulsory legal disclosure is probably small and the more serious

matter of revealing medical information in connection with a crime rather than a civil action has already been referred to. Even if patients (*ie* society) accepted that we might reveal personal information to others in very special circumstances we should not get blasé about telling third parties about our patients.

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